NEW YORK STATE

Office of the Medicaid Inspector General

# Audit Protocol
# OMH Community Rehabilitation Services for Adults

For Service Dates 1/1/17 through 2/25/26 (Revised 3/4/26)

MAY 7, 2026

# “Our mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.”

OFFICE OF THE MEDICAID INSPECTOR GENERAL MISSION STATEMENT

# New To 2026 Protocols: Public Health Emergency (PHE)

During the PHE, services provided and billed in accordance with COVID-19 PHE guidance issued by the NYS Department of Health (DOH) and/or Centers for Medicare and Medicaid Services (CMS) pertaining to Hospice services will not be subject to disallowance, provided all other programmatic and billing requirements not altered or waived by the PHE guidance were met.

| Agency | Guidance Title | Date Issued | Date(s) Revised |
|---|---|---|---|
| OMH | Use of Telephone and Two-way Video Technology by OMH-Licensed, Funded or Designated Providers and Clients Affected by the COVID-19 Pandemic | 03/30/20 | 02/12/21 |
| OMH | COVID-19 Documentation Guidance for Adult and Children's Residential Programs | 04/13/20 | |
| OMH | New York State Office of Mental Health COVID-19 Disaster Emergency FAQ | 04/16/20 | 07/13/20 |
| OMH | Commissioner's Regulatory Waiver | 06/25/21 | 06/28/21, 08/23/21, 10/23/21, 12/07/21, 02/05/22, 06/06/22, 10/04/22, 02/01/23 |

The Federal Government announced that the PHE expired at the end of the day on May 11, 2023. On the date the PHE ended, the flexibilities afforded providers regarding minimum billing standards and documentation requirements also ended, unless otherwise specified by OMH through formal regulatory waivers. The OMH Commissioner's waiver, which was last renewed on February 1, 2023 and contained the COVID-19-related flexibilities, terminated on the same date that the PHE ended.

# New To 2026 Protocols: New Protocols Added

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| 1 | Missing Recipient Record |
| 8 | Staff Member Documented as Delivering the Rehabilitation Service Absent on Date of Service |
| 19 | Services Ordered / Referred by Individual Not Enrolled in NYS Medicaid |
| 20 | Services Ordered / Prescribed / Referred / Attended by Excluded Individual |

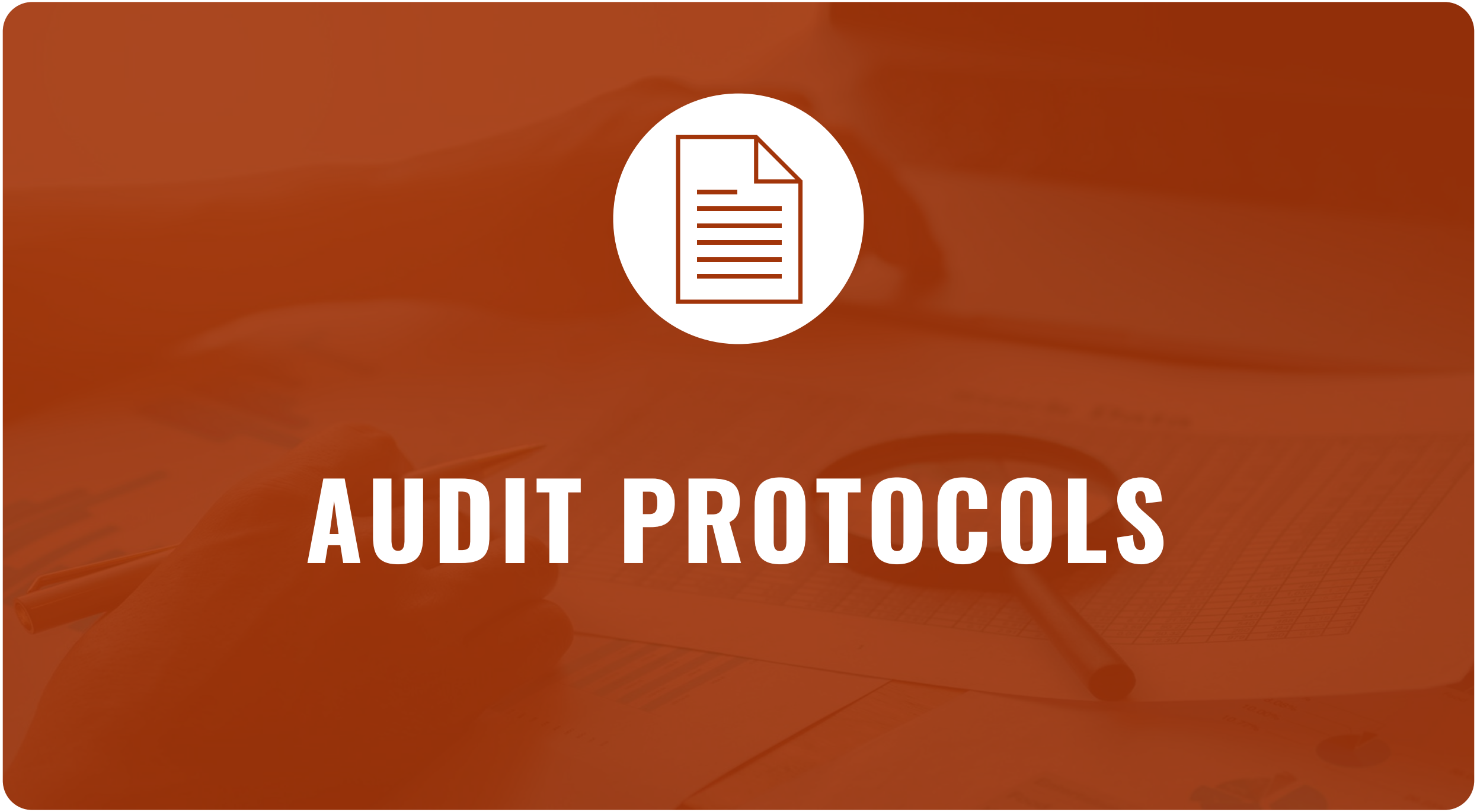
# Overview of Changes: Rehab Protocols 2016 vs. 2026

## 8 Protocols (2016)

- 3. Failure to Document Four Different Rehabilitation Services For a Full Month Claim
- 4. Failure to Document Two Different Rehabilitation Services For a Half Month Claim
- 7. Failure to Perform Rehabilitation Services on Different Days
- 8. Failure to Meet Minimum Duration Requirements
- 10. Duration of Rehabilitation Service Not Documented
- 11. Failure to Document Date Rehabilitation Service Performed
- 12. Billing for Non-Reimbursable Contact
- 13. Failure to Document Staff Person Providing Rehabilitation Service

## Were Condensed into 2 (2026)

- 4. Failure to Document at Least Four Billable Contacts for a Full Month Claim
- 5. Failure to Document at Least Two Billable Contacts for a Half Month Claim


AUDIT PROTOCOLS

# 1. MISSING RECIPIENT RECORD

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| OMIG Audit Criteria | The claim will be disallowed if the recipient record is not available for review. |
| Regulatory References | 14 NYCRR § 595.14(a)<br>14 NYCRR § 595.14(b)(8)<br>18 NYCRR § 504.3(a)<br>18 NYCRR § 540.7(a)(8)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section III |

# 2. MISSING DOCUMENTATION OF REHABILITATION SERVICE

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| OMIG Audit Criteria | The claim will be disallowed if the record does not document any rehabilitation services for the month under review. |
| Regulatory References | 14 NYCRR § 595.14(a)<br>14 NYCRR § 595.14(b)(8)<br>18 NYCRR § 504.3(a)<br>18 NYCRR § 540.7(a)(8)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section III |

# 3. MISSING PROGRESS NOTE

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| OMIG Audit Criteria | The claim will be disallowed if a progress note was not completed at least monthly by a staff member of the program which indicates the type of community rehabilitation services which have been provided, any significant events which have occurred and, if appropriate, any recommendations for changes to the goals and objectives of the service plan. |
| Regulatory References | 14 NYCRR § 593.6(e)<br>14 NYCRR § 595.11(c)<br>14 NYCRR § 595.14(b)(7) |

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# 4. FAILURE TO DOCUMENT AT LEAST FOUR BILLABLE CONTACTS FOR A FULL MONTH CLAIM

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| OMIG Audit Criteria | To bill for a full month claim, the eligible resident must receive at least four discrete billable contacts. A billable contact must:<br>• Include at least one of the following services, as indicated in the resident's service plan, with a staff person of the program: (1) Assertiveness/Self advocacy Training; (2) Community Integration; (3) Daily Living Skills; (4) Health Services; (5) Medication Management & Training; (6) Parenting Training; (7) Rehabilitation Counseling; (8) Skill Development; (9) Socialization; (10) Substance Abuse Services; (11) Symptom Management;<br>• Indicate the date of service and the name of the staff person rendering the service;<br>• Indicate the duration of service which must be at least 15 minutes;<br>• Only be counted once for each day; and,<br>• Not be performed at the site of a licensed mental health outpatient program, or when the resident was an inpatient at a hospital or residing at another licensed residential facility, or otherwise not performed face-to-face. Face to face services include services provided using audio-visual or audio-only telehealth, where approved or otherwise authorized.<br>A full month claim will be reduced to a half month claim if the resident received at least two, but less than four, billable contacts during the month. The entire claim will be disallowed if the resident received less than two billable contacts during the month. |
| Regulatory References | 14 NYCRR § 593.4(b)<br>14 NYCRR § 593.7(b)(1)<br>14 NYCRR § 593.7(b)(3)<br>14 NYCRR § 593.7(b)(5)<br>14 NYCRR § 595.14(b)(8)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines<br>Version 2006-1, Sections I and III |

# 5. FAILURE TO DOCUMENT AT LEAST TWO BILLABLE CONTACTS FOR A HALF MONTH CLAIM

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| OMIG Audit Criteria | To bill for a half month claim, the eligible resident must receive at least two discrete billable contacts. A billable contact must:<br>• Include at least one of the following services, as indicated in the resident's service plan, with a staff person of the program: (1) Assertiveness/Self advocacy Training; (2) Community Integration; (3) Daily Living Skills; (4) Health Services; (5) Medication Management & Training; (6) Parenting Training; (7) Rehabilitation Counseling; (8) Skill Development; (9) Socialization; (10) Substance Abuse Services; (11) Symptom Management;<br>• Indicate the date of service and the name of the staff person rendering the service;<br>• Indicate the duration of service which must be at least 15 minutes;<br>• Only be counted once for each day; and,<br>• Not be performed at the site of a licensed mental health outpatient program, or when the resident was an inpatient at a hospital or residing at another licensed residential facility, or otherwise not performed face-to-face. Face to face services include services provided using audio-visual or audio-only telehealth, where approved or otherwise authorized.<br>A half month claim will be disallowed if the resident received less than two billable contacts during the month. |
| Regulatory References | 14 NYCRR § 593.4(b)<br>14 NYCRR § 593.7(b)(1)<br>14 NYCRR § 593.7(b)(3)<br>14 NYCRR § 593.7(b)(5)<br>14 NYCRR § 595.14(b)(8)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines<br>Version 2006-1, Sections I and III |

# 6. RECIPIENT NOT IN RESIDENCE 21 DAYS IN MONTH

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| OMIG Audit Criteria | If the recipient was in residence less than 21 days but 11 days or more, the full month claim will be reduced to a half month claim and the difference will be disallowed. If the recipient was in residence less than 11 days in the month, the entire full month claim will be disallowed. |
| Regulatory References | 14 NYCRR § 593.7(b)(1)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section III |

# 7. RECIPIENT NOT IN RESIDENCE 11 DAYS IN MONTH

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|---|---|
| OMIG Audit Criteria | If the recipient was in residence less than 11 days in the month, the entire half month claim will be disallowed. |
| Regulatory References | 14 NYCRR § 593.7(b)(2)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section III |

# 8. STAFF MEMBER DOCUMENTED AS DELIVERING THE REHABILITATION SERVICE ABSENT ON DATE OF SERVICE

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| OMIG Audit Criteria | If the provider's records indicate that the staff member documented as delivering the rehabilitation service was absent when the service was delivered, that service will not be counted as a billable contact. A full monthly claim will be reduced to a half monthly claim if the resident received at least two, but less than four, billable contacts during the month. The entire claim will be disallowed if the resident received less than two billable contacts during the month. |
| Regulatory References | 14 NYCRR § 593.7(b)<br>14 NYCRR § 595.14(b)(8)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section III |

# 9. MISSING ADMISSION NOTE

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| OMIG Audit Criteria | If an admission note was not documented at the time of admission, the claim will be disallowed. This finding only applies to services within the first four weeks of admission where a service plan had not yet been completed. |
| Regulatory References | 14 NYCRR § 593.6(c)<br>14 NYCRR § 595.11(a) |

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# 10. ADMISSION NOTE NOT COMPLETED BY A QUALIFIED MENTAL HEALTH STAFF PERSON (QMHSP)

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| OMIG Audit Criteria | The claim will be disallowed if the admission note was not completed by a Qualified Mental Health Staff Person. This finding only applies to services within the first four weeks of admission where a service plan had not yet been completed. |
| Regulatory References | 14 NYCRR § 593.6(c)<br>14 NYCRR § 595.4(a)(10)<br>14 NYCRR § 595.11(a) |

# 11. MISSING INITIAL PHYSICIAN AUTHORIZATION

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|---|---|
| OMIG Audit Criteria | The claim will be disallowed if the record does not have the initial physician authorization or the initial authorization was signed by an unauthorized person (e.g., nurse practitioner, social worker or therapist). |
| Regulatory References | 14 NYCRR § 593.6(a)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section I |

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# 12. REHABILITATION SERVICE PROVIDED NOT INCLUDED IN SERVICE PLAN

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| OMIG Audit Criteria | If the community rehabilitation service provided is not specified on the resident's service plan, then that service is not counted as a billable contact. A full monthly claim will be reduced to a half monthly claim if the resident received at least two, but less than four, billable contacts during the month. The entire claim will be disallowed if the resident received less than two billable contacts during the month. |
| Regulatory References | 14 NYCRR § 593.7(b)(4)<br>14 NYCRR § 595.11(b)(5)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section I |

# 13. MISSING RENEWAL / REAUTHORIZATION OF AUTHORIZATION

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| OMIG Audit Criteria | The claim will be disallowed if the reauthorization is missing from the record or the reauthorization was signed by an unauthorized person (social worker or therapist) |
| Regulatory References | 14 NYCRR § 593.6(b)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section I |

# 14. AUTHORIZATION LACKS REQUIRED AUTHORIZATION PERIOD

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| OMIG Audit Criteria | The claim will be disallowed if the authorization for the recipient to receive services lacks an authorization period. |
| Regulatory References | 14 NYCRR § 593.6(a)(2) |

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# 15. MISSING SERVICE PLAN / SERVICE PLAN REVIEW

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| OMIG Audit Criteria | The claim will be disallowed if a service plan was not developed within four weeks of admission to the program, or if a subsequent service plan review effective for the services under review was not completed. |
| Regulatory References | 14 NYCRR § 593.6(c)<br>14 NYCRR § 593.6(f)<br>14 NYCRR § 595.1(b)<br>14 NYCRR § 595.11(a)<br>14 NYCRR § 595.11(d)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section I |

# 16. SERVICE PLAN / SERVICE PLAN REVIEW NOT REVIEWED AND SIGNED BY QUALIFIED MENTAL HEALTH STAFF PERSON (QMHSP)

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| OMIG Audit Criteria | The claim will be disallowed if the service plan/review effective for the services under review was not signed by a Qualified Mental Health Staff Person. |
| Regulatory References | 14 NYCRR § 593.6(d)<br>14 NYCRR § 593.6(f)(3)<br>14 NYCRR § 595.4(a)(10)<br>14 NYCRR § 595.11(b)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section I |

# 17. BILLING MEDICAID FOR UNLICENSED RESIDENCE

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| OMIG Audit Criteria | Claims will be disallowed for services to individuals residing at a residence that did not have a valid operating certificate when the services were rendered. |
| Regulatory References | 14 NYCRR § 593.5(a)<br>14 NYCRR § 595.5(a)<br>14 NYCRR § 595.5(e)<br>Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines Version 2006-1, Section III |

# 18. RECIPIENT EXCESS INCOME ("SPEND DOWN") NOT APPLIED PRIOR TO BILLING MEDICAID

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| OMIG Audit Criteria | The spend-down amount should be applied beginning with the first service rendered in the month and each service thereafter until the spend-down is exhausted. Each claim subject to a spend-down application that was billed to Medicaid before the spend-down was met will be disallowed. |
| Regulatory References | 18 NYCRR § 360-4.8(c)(1)<br>18 NYCRR § 360-4.8(c)(2)(ii)<br>18 NYCRR § 504.3(e)<br>18 NYCRR § 518.1(c) |

# 19. SERVICES ORDERED / REFERRED BY INDIVIDUAL NOT ENROLLED IN NYS MEDICAID

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| OMIG Audit Criteria | Claims for services ordered/referred by an individual not enrolled in the New York State Medicaid program when the services were ordered/referred, as required, will be disallowed. |
| Regulatory References | 42 C.F.R. § 455.410(b)<br>42 C.F.R. § 455.440<br>18 NYCRR § 504.1(b)<br>18 NYCRR § 504.6(b)-(d)<br>18 NYCRR § 504.9(a)<br>18 NYCRR § 513.1(d), (e), and (g)<br>NYS DOH Medicaid Update, Special Edition December 2013, Vol. 29, No. 13<br>NYS DOH Medicaid Update, June 2024, Vol. 40, No. 6<br>NYS DOH Medicaid Update, May 2017, Vol. 33, No. 5<br>NYS DOH Medicaid Update, March 2013, Vol. 29, No. 4<br>NYS DOH Medicaid Update, June 2012, Vol. 28, No. 7<br>NYS DOH Medicaid Update, April 2011, Vol. 27, No. 5 |

# 20. SERVICES ORDERED / PRESCRIBED / REFERRED / ATTENDED BY EXCLUDED INDIVIDUAL

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|---|---|
| OMIG Audit Criteria | Claims for services ordered, prescribed, referred, or attended by an individual excluded from the New York State Medicaid program when the services were ordered, prescribed, referred, or attended will be disallowed. |
| Regulatory References | 18 NYCRR § 504.7(d)(1)<br>18 NYCRR § 513.1(d), (e), and (g)<br>18 NYCRR § 515.1(b)(6) and (10)<br>18 NYCRR § 515.5(a)-(c) and (e)<br>NYS DOH Medicaid Update, Special Edition December 2013, Vol. 29, No. 13<br>NYS DOH Medicaid Update, April 2010, Vol. 26, No. 6 |

# AGENCY CONTACT & RESOURCE INFORMATION

- OMIG main office phone: 518-473-3782
- Website: www.omig.ny.gov
- Bureau of Medicaid Fraud Allegations: Medicaid Fraud Hotline: 877-873-7283; email: bmfa@omig.ny.gov
- Division of Medicaid Audit email: audit@omig.ny.gov
- Bureau of Compliance email: compliance@omig.ny.gov; phone: (518) 408-0401
- Self-Disclosure Unit email: selfdisclosures@omig.ny.gov; phone: (518) 402-7030
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